



Fermilab

Date _____

Medical Surveillance Request for Respiratory Protection Usage

Name _____

I.D. _____

____ Lab Employee

Division/ Section _____

____ Contractor/ Consultant

Employer _____

____ User/ Other

Institution _____

Respirator Type(s)* (Please Check):

____ Self-Contained Breathing Apparatus (SCBA)

____ BioMarine BioPak 240 (BMBP)

____ Air-line Respirator Loose-Fitting (ALRLF)

____ Air-line Respirator Tight-Fitting (ALRTF)

____ Powered Air-Purifying Respirator Loose-Fitting (PAPRLF)

____ Powered Air-Purifying Respirator Tight-Fitting (PAPRTF)

____ Negative Pressure Air-Purifying Respirator (APR)

Supplemental Respirator Information:

Respirator Use Duration _____ hours

Respirator Use Frequency (Circle one) day week month year

Description of work being performed _____

Additional Personal Protective Equipment Required _____

Temperature Extremes _____ Humidity Extremes _____

Supervisor or ES&H Representative

Date

*The physician or other licensed health care provider shall be shown examples of the various types of respirator protection by the ES&H section.

DISTRIBUTION: Medical

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Fermilab ES&H Manual

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http://www-esh.fnal.gov/pls/default/esh_manuals.html.